UNITED STATES DISTRICT COURT

for the

Northern District of Georgia

_Civil_____Division

Deon D. Jones
Civil Action # 19-A-12757-7

Plaintiff(s)
(Write the full name of each plaintiff who is filing this complaint. If the names of all the plaintiffs cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

-v-

Gwinnett County superior Court
Tadia Whitner, Judge

Defendant(s)
(Write the full name of each defendant who is being sued. If the names of all the defendants cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names. Do not include addresses here.)

Case No. 1:20-CV-3395
(to be filled in by the Clerk's Office)

Jury Trial: *(check one)* ☑ Yes ☐ No

COMPLAINT FOR VIOLATION OF CIVIL RIGHTS
(Non-Prisoner Complaint)

NOTICE

Federal Rules of Civil Procedure 5.2 addresses the privacy and security concerns resulting from public access to electronic court files. Under this rule, papers filed with the court should *not* contain: an individual's full social security number or full birth date; the full name of a person known to be a minor; or a complete financial account number. A filing may include *only*: the last four digits of a social security number; the year of an individual's birth; a minor's initials; and the last four digits of a financial account number.

Except as noted in this form, plaintiff need not send exhibits, affidavits, grievance or witness statements, or any other materials to the Clerk's Office with this complaint.

In order for your complaint to be filed, it must be accompanied by the filing fee or an application to proceed in forma pauperis.

I. The Parties to This Complaint

A. The Plaintiff(s)

Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.

Name	Deon D. Jones		
Address	2571 Forrester Ct		
	Lithia Springs	GA	30122
	City	*State*	*Zip Code*
County	Douglas		
Telephone Number	(470)432-1752		
E-Mail Address	deonjones1979@gmail.com		

B. The Defendant(s)

Provide the information below for each defendant named in the complaint, whether the defendant is an individual, a government agency, an organization, or a corporation. For an individual defendant, include the person's job or title (if known) and check whether you are bringing this complaint against them in their individual capacity or official capacity, or both. Attach additional pages if needed.

Defendant No. 1

Name	Gwinnett County Superior Court		
Job or Title *(if known)*			
Address	75 Langly Drive		
	Lawrenceville	GA	30046
	City	*State*	*Zip Code*
County	Gwinnett		
Telephone Number	(770)822-8100		
E-Mail Address *(if known)*	Web Administrator		

☐ Individual capacity ☑ Official capacity

Defendant No. 2

Name	Tadia Whitner		
Job or Title *(if known)*	Judge		
Address	75 Langly Drive		
	Lawrenceville	GA	30046
	City	*State*	*Zip Code*
County	Gwinnett		
Telephone Number	(770)822-8100		
E-Mail Address *(if known)*	Web Administrator		

☐ Individual capacity ☑ Official capacity

Defendant No. 3

Name

Job or Title *(if known)*

Address

City *State* *Zip Code*

County

Telephone Number

E-Mail Address *(if known)*

☐ Individual capacity ☐ Official capacity

Defendant No. 4

Name

Job or Title *(if known)*

Address

City *State* *Zip Code*

County

Telephone Number

E-Mail Address *(if known)*

☐ Individual capacity ☐ Official capacity

II. Basis for Jurisdiction

Under 42 U.S.C. § 1983, you may sue state or local officials for the "deprivation of any rights, privileges, or immunities secured by the Constitution and [federal laws]." Under *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics, 403 U.S. 388 (1971)*, you may sue federal officials for the violation of certain constitutional rights.

A. Are you bringing suit against *(check all that apply)*:

☐ Federal officials (a *Bivens* claim)

☑ State or local officials (a § 1983 claim)

B. Section 1983 allows claims alleging the "deprivation of any rights, privileges, or immunities secured by the Constitution and [federal laws]." 42 U.S.C. § 1983. If you are suing under section 1983, what federal constitutional or statutory right(s) do you claim is/are being violated by state or local officials?

Fourteenth Amendment-due process of the law,
Freedom from discrimination for protected classes (see, race and national origin),
The right to petition the government,Freedom of speech, religion, assembly,
Cruel and unusual punishment
Abuse by a public official

C. Plaintiffs suing under *Bivens* may only recover for the violation of certain constitutional rights. If you are suing under *Bivens*, what constitutional right(s) do you claim is/are being violated by federal officials?

D. Section 1983 allows defendants to be found liable only when they have acted "under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia." 42 U.S.C. § 1983. If you are suing under section 1983, explain how each defendant acted under color of state or local law. If you are suing under *Bivens*, explain how each defendant acted under color of federal law. Attach additional pages if needed.

The Plaintiff "clearly" "did not" file a Malpractice Compaint
Riffle v. Armstrong. 477 S.E.2d 535 (W.Va.Sup.Ct 1996)
Sassaali v. DeFauw,696 N.E.2d 1217 (Ill.App.Ct. 1998)
Liles v. P.I.A Medifield, 681 S0.2d 711 (Fla.Dist.Ct.Ap. 1996)
Lubera v. Jewish Association For Services for the Aged, 1996 W.I., 426375 (S.D.N.Y. 1996)

III. Statement of Claim

State as briefly as possible the facts of your case. Describe how each defendant was personally involved in the alleged wrongful action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If more than one claim is asserted, number each claim and write a short and plain statement of each claim in a separate paragraph. Attach additional pages if needed.

A. Where did the events giving rise to your claim(s) occur?

The Superior Court of Gwinnett County State of Georgia

B. What date and approximate time did the events giving rise to your claim(s) occur?

March 5th, 2020 at approximately 10 Am.

C. What are the facts underlying your claim(s)? *(For example: What happened to you? Who did what? Was anyone else involved? Who else saw what happened?)*

What is clear is that I did not file a medical malpractice lawsuit and nothing with medical malpractice legaly applies.This is Gwinnett County participating in a hate crime orchestrated by the Atlanta Veterans Administration, WellStar Health Systems, Inc., Puckett Emergency Medical Services and Summit Ridge Hospital. Deon D. Jones v. WellStar Health Systems Inc., Civil Action:19-A-12757-7 is being played out in the Superior Court of Cobb County State of Georgia presently. I will file a Motion for Change of Venue from Cobb County to the Northern District Court as I will do with this case because this is a well documented hate crime which to my knowledge and belief put's my life in danger as Judge Tadia Whitner demonstrated in her court room on March 5, 2020 when she violated my civile rights and had me chased out of the court room by the Sheriff's and witnessed by everyone in the court room. If you have video footage of the hearing, it would show validity to my claim. The Courts records of the hearing is also proof the Judge Tadia Whitner is a criminal and should be arrested immediately and charged with a hate crime. The record show absolute proof and speaks for itself. I did not file a medical malpractice lawsuit.

D. Additional page attached

Section 1983 allows defendants to be found liable only when they have acted "under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia." 42 U.S.C. § 1983. If you are suing under section 1983, explain how each defendant acted under color of state or local law. If you are suing under *Bivens*, explain how each defendant acted under color of federal law. Attach additional pages if needed.

Continued:

Plumadore v. New York 427 N.Y.App.Div. 1980)

Chadwick v. Al-Basha, 692 N.E.2d 390 (Ill.App.Ct.1998)

Demarco v. Sadiker, 952 F. Supp. 134 (E.D.N.Y. 1996)

Dick v. Watonwa, 562 F. Supp. 1083 (D.Minn. 1983)(illegal confinement liability)

Foshee v. Health Management Associates, 675 S0.2d 957 (Fla.Dist.Ct.App. 1996)

James H. v. Ohio D.M.H., 439 N.E.2d 437 (OhioCt.App. 1982)

C.

What are the facts underlying your claim(s)? *(For example: What happened to you? Who did what? Was anyone else involved? Who else saw what happened?)*

Continued:

The Courts records of the hearing is also proof the Judge Tadia Whitner is a criminal and should be arrested immediately and charged with a hate crime. The record show absolute proof and speaks for itself. I did not file a medical malpractice lawsuit.

What Judge Tadia Whitner has done put's not only targeted veterans by the criminal Veterans Administration lives at risk; but the public at large by abducting innocent citizens, violating their civil rights, taking away their freedom which they have no authority while drugging them up to the point of death with morphine and other opioid cocktails.

Cont.

What is even more frightening is they openly violated my civil rights and openly showed they had no authority and no legal paperwork; which automatically proves false imprisonment and could easily been determined at the hearing. However Judge Tadia Whitner decided she would be the one to throw her career away on the bench because I am certainly going to demand it from the Justice Department. Even worse, Gwinnett County Police refused to take a police report and charge Summit Ridge with a crime leaving another attempt on my life imminent and Gwinnett County/Judge Tadia Whitner will be an accomplice to the crime by violating the oath of office.

The Hearing lasted lest then 5 minutes and She refused to let me show any evidence nor did the Defendant present any evidence. When I recited case law showing validity to my claim; she laughed and said I should have wrote that in my answer but I didn't so; case dismissed. When I said could I appeal her decision; she nodded at the Sheriff and he rushed over to me and told me to get out and scared me half to death. I didn't even have time to put my documents away and by time I left the court room; there were three officer's that followed me out of the building. I was afraid for my life and frightened that I was about to get snatched again.

Everyone in the court room at that time witnessed my claim and the court reporters records will document exactly the same thing as my statement.

This is not just a civil matter; but a criminal matter which shows proof positive that Gwinnett County is helping and a intricate part in a crime ring orchestrated by the Veterans Administration and multiple lawsuits are in the process of being filed and served.

IV. Injuries

If you sustained injuries related to the events alleged above, describe your injuries and state what medical treatment, if any, you required and did or did not receive.

Because Gwinnett County violated my civil rights of due process; I lost the value of the Civil Action File Number 19-A-12757-7 which is well over $150 million in damages as well as the financial hardship that I have endured because of Judge Tadia Whitner willfully violation her oath of office. I have had to file bancruptcy in the last few weeks and I am about to become homless due to this hate crime which Gwinnett County is fully and willingly participating in and is well documented.

I am enduring great emotional distress which is deminishing my quality of life and it is intention emotional distress inflicted by Gwinnett County, The Veterans Administration, Summit Ridge Hospital, WellStar Health Systems, Inc., and Puckett Emergency Medical Services.

V. Relief

State briefly what you want the court to do for you. Make no legal arguments. Do not cite any cases or statutes. If requesting money damages, include the amounts of any actual damages and/or punitive damages claimed for the acts alleged. Explain the basis for these claims.

I want the court to pay me the damages lost in Civil Action: 19-12757-7 when my civil rights was violated by refusal of due process by this court.

I want Civil Action: 19-12757-7 to be immediately reopened and a change of Venue be granted to the Northern Middle District Court of Georgia.

I want Judge Tadia Whitner to be immediately removed from the bench and be charged with a hate crime.

I want the Court to pay $50 million in punitive damages for their egregious and openly criminal actions of aiding and abetting criminal doctors at Summit ridge Hospital while putting not only veterans lives at risk; but the public at large.

I want Doctor R. Norniella MD at Summit ridge Hospital arrested immediately and charged with false imprisonment, assault and battery and fraud.

VI. Certification and Closing

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

A. For Parties Without an Attorney

I agree to provide the Clerk's Office with any changes to my address where case–related papers may be served. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Date of signing: 08/14/2020

Signature of Plaintiff Deon D. Jones

Printed Name of Plaintiff Deon D. Jones

B. For Attorneys

Date of signing: _____

Signature of Attorney _____

Printed Name of Attorney _____

Bar Number _____

Name of Law Firm _____

Address _____

_____ _____ _____

City *State* *Zip Code*

Telephone Number _____

E-mail Address _____

VA | U.S. Department of Veterans Affairs
Office of General Counsel

Torts Law Group (021)
810 Vermont Avenue, NW
Washington, DC 20420

Phone: (202) 809-8513

In Reply Refer To: GCL 447247

November 19, 2019

Deon D. Jones
2571 Forrester Ct.
Lithia Springs, GA 30122

RE: Administrative Tort Claim

Dear Mr. Jones:

The U.S. Department of Veterans Affairs (VA) received your tort claim on September 23, 2019.

VA has six months from the date your claim was received to consider a claim before you may file suit in federal district court pursuant to the Federal Tort Claims Act (FTCA), sections 1346(b), 2401(b), and 2671-2680, title 28, United States Code.

If you have not been contacted after six (6) months from the date your claim was received, you may contact Attorney Reshawna Banks at (202) 809-8513.

A combination of federal and state laws governs FTCA claims; some state laws may limit or bar a claim or lawsuit. VA staff handling FTCA claims work for the Federal Government, and cannot provide legal advice on state or federal law filing requirements.

Sincerely,

Annie L King
Annie King
Legal Assistant

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:

Department of Veterans Affairs
Torts Law Group
810 Vermont Ave N.W.
Washington, D.C 20420

2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.

Deon Dorsey Jones
2571 Forrester Ct
Lithia Springs, GA 30122

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☒ CIVILIAN	12/28/1960	Divorced	12/15/2017	11 A.M.

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

False imprisonment, Emotional Distress, Intentional Emotional Distress, Medical Malpractice, Fraud
12/15/2017 thru 12/17/2017 at VA Austell, GA Community clinic and WellStar Cobb Hospital and then again 12/2[illegible]/2017 at VA Atlanta VA Hospital and then transferred against my will to Summit Ridge Mental Institution 12/22/2017 thru 12/28/2017.
This was a hit on my life and the evidence shows that it was sanctioned all the way up to the the White House.
There is evidence and complaints filed and no Impact statement is needed. They are responsible for the death my Parents.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side).

10. PERSONAL INJURY/WRONGFUL DEATH

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

I have PTSD from being abducted and false imprisonment which not only led to my PTSD, back injury, left knee injury, pancreatic attacks and led to my Mother having a heart attack and passing away on 3/6/2018 and subsequently my father passing away 20 days later on 3/26/2018 from the stress of my abduction from the VA. I still feel like my life is in jeopardy and the next time they will have to out right murder me.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
Derrick Jones	7856 Emily Way Greenbelt, MD 20770

12. (See instructions on reverse). AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights).
	$250,000,000		$250,000,000

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).	13b. PHONE NUMBER OF PERSON SIGNING FORM	14. DATE OF SIGNATURE
Deon D. Jones	(678)437-7279	09/19/2019

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM

The claimant is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).

CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS

Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

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95-109

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STANDARD FORM 95 (REV. 2/2007)
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

Exhibit F

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:	2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.
Department of Veterans Affairs Tort Law Group 810 Vermont Ave. Washington D.C 20420	Deon Dorsey Jones 2571 Forrester CT Lithia Springs, GA 30122

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☒ CIVILIAN	12/28/1960	Divorced	2/14/2020	

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

Defamation of Charecter and Gross Negligence in the abduction, false imprisonment, attempted murder, fraud and assult and battery reported in previous SF-95 Notice to Sue which was recieved by your Office on September 23, 2019 and is assigned to Attorney Rashawna Banks. This is a hate crime orchestrated by the United States to silence me and tried to murder me at WellStar Cobb Hospital by injecting me with Morphine and another opiod cocktail. (See additional sheet and numerous exhibits)

9. **PROPERTY DAMAGE**

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side).

10. **PERSONAL INJURY/WRONGFUL DEATH**

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

Defamation of character, intentional emotional disteress and gross negligence

11. **WITNESSES**

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
See Police Reports and criminally altered	medical records by the VA, WellStar Health Systems and Summit Ridge Hospita

12. (See instructions on reverse). **AMOUNT OF CLAIM** (In dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights).
	One Billion Dollars		One Billion Dollars

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).	13b. PHONE NUMBER OF PERSON SIGNING FORM	14. DATE OF SIGNATURE
Deon D. Jones	(470) 432-1752	8/10/2020

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

Department of Veterans Affairs

CIVIL RIGHTS DISCRIMINATION COMPLAINT

USE AN ADDITIONAL SHEET OF PAPER TO ANSWER ANY QUESTION IF NECESSARY.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, Code of Federal Regulations, Chapter 1, Parts 15 and 18, and is used by patients and other VHA customers to file a formal complaint for alleged violations of their civil rights pertaining to race, color, sex, national origin, age, disability, or reprisal. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 16VA026 Litigant, Tort Claimant, EEO Complainant, and Third Party Recovery Files-VA and 63VA05 Grievance Records-VA published in the Federal Register. Disclosure is voluntary, however, failure to furnish the information will result in our inability to process your request promptly and adjudicate your grievance needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Completion of this form is entirely voluntary. Failure to complete the form will have no adverse impact on any benefits to which you may have been entitled. The purpose of this information collection is to help you explain an event you consider discriminatory.

1. NAME *(Last, First, Middle Initial)*	2. MAILING ADDRESS
Jones, Deon, Dorsey	4035 Landover Court Austell, Georgia 30106
3A. WORK TELEPHONE NO. *(Include area code)*	
3B. HOME TELEPHONE NO. *(Include area code)*	4. NAME AND ADDRESS OF VA FACILITY OR OTHER AGENCY WHERE DISCRIMINATION OCCURRED.
(678) 437-7279	250 Scenic Hwy S, Lawrenceville, GA 30046

5. NAME OF SERVICE/PRODUCT LINE WHERE DISCRIMINATION OCCURRED.	6. NAME OF INDIVIDUAL *(If known)* WHO DISCRIMINATED *(Include phone number)* OR IDENTIFY THE DISCRIMINATORY PRACTICE.	7. DATE OF DISCRIMINATION *(Include the most recent date(s)*
Summit Ridge Hospital Lawrenceville, GA	Abuse of Authority/False Imprisonment	12/22/2017

8. BASIS (For each claim you believe was discriminatory, list the bases for your complaint) *(You may list one or more)*:

- [X] A. RACE *(Specify below)*
  - ( ) American Indian
  - ( ) Asian
  - ( ) White
  - ( ) Native Hawaiian or Other Pacific Islander
  - (•) Black or African American
- [ ] B. ETHNICITY *(Specify below)*
  - ( ) Spanish / Hispanic / Latino
  - ( ) Not Spanish / Hispanic / Latino
- [ ] C. NATIONAL ORIGIN *(Specify)*
- [ ] D. SEX
  - ( ) Male
  - ( ) Female
- [X] E. AGE *(Date of birth)* 12/28/1960
- [X] F. DISABILITY
  - (•) Physical
  - ( ) Mental

9. ISSUE(S) *(If your complaint concerns discrimination in the delivery of services, or employment, briefly describe what happened below.)*

False allegations from the VA, Abuse of Authority and False Inprisonment in the Atlanta VA Clinic Mental Health Deparment against my will 12/21/2017 thru 12/22/2017. VA Mental Health transferred me against my will on 12/22/2017 thru 12/28/2017 to Summit Ridge Hospital. (Exhibit A thru Z)

10. LIST THE MOST CONVENIENT TIME AND PLACE FOR YOU TO BE CONTACTED REGARDING THIS COMPLAINT	11. PLEASE PROVIDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ATTORNEY OR REPRESENTATIVE *(If applicable)*.
anytime	

12. IF THE DISCRIMNATORY ACT DESCRIBED ABOVE OCCURRED MORE THAN 180 DAYS AGO, PLEASE EXPLAIN WHY YOU WAITED UNTIL NOW TO FILE A COMPLAINT.

13. LIST ANY PERSON *(Witness, fellow employee)* WHO CAN SUPPORT YOUR ALLEGATION *(List name, address, telephone number)*	14. HAVE YOU FILED THIS COMPLAINT WITH ANOTHER AGENCY? *(If yes, provide the name and address)* [X] YES [ ] NO
VA Police Report, VA Medical Reports, WellStar, Summit Ridge Hospital Records Exhibit A thru Z.	OIG

15. WHAT REMEDY ARE YOU SEEKING FOR THE ALLEGED DISCRIMINATION LISTED ABOVE?

Legal and Monetary

16. SIGNATURE *(Sign in ink)*	17. DATE *(mm/dd/yyyy)*
Deon D. Jones	04/01/2018

VA FORM NOV 2005 **10-0381**

Department of Veterans Affairs

CIVIL RIGHTS DISCRIMINATION COMPLAINT

USE AN ADDITIONAL SHEET OF PAPER TO ANSWER ANY QUESTION IF NECESSARY.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, Code of Federal Regulations, Chapter 1, Parts 15 and 18, and is used by patients and other VHA customers to file a formal complaint for alleged violations of their civil rights pertaining to race, color, sex, national origin, age, disability, or reprisal. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 16VA026 Litigant, Tort Claimant, EEO Complainant, and Third Party Recovery Files-VA and 63VA05 Grievance Records-VA published in the Federal Register. Disclosure is voluntary, however; failure to furnish the information will result in our inability to process your request promptly and adjudicate your grievance needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Completion of this form is entirely voluntary. Failure to complete the form will have no adverse impact on any benefits to which you may have been entitled. The purpose of this information collection is to help you explain an event you consider discriminatory.

1. NAME *(Last, First, Middle Initial)*	2. MAILING ADDRESS
Jones, Deon, Dorsey	4035 Landover Court Austell, Georgia 30106
3A. WORK TELEPHONE NO. *(Include area code)*	
3B. HOME TELEPHONE NO. *(Include area code)*	4. NAME AND ADDRESS OF VA FACILITY OR OTHER AGENCY WHERE DISCRIMINATION OCCURRED.
(678)437-7279	VA Austell Clinic 2041 Mesa Valley Way Austell, GA 30106

5. NAME OF SERVICE/PRODUCT LINE WHERE DISCRIMINATION OCCURRED.	6. NAME OF INDIVIDUAL *(If known)* WHO DISCRIMINATED *(Include phone number)* OR IDENTIFY THE DISCRIMINATORY PRACTICE.	7. DATE OF DISCRIMINATION *(Include the most recent date(s)*
VA Austell Clinic Mental Health Dept	Abuse of Authority/False Imprisonment	12/15/2017

8. BASIS (For each claim you believe was discriminatory, list the bases for your complaint) *(You may list one or more)*:

- [X] A. RACE *(Specify below)*
  - ( ) American Indian
  - ( ) Asian
  - ( ) White
  - ( ) Native Hawaiian or Other Pacific Islander
  - (•) Black or African American
- [ ] B. ETHNICITY *(Specify below)*
  - ( ) Spanish / Hispanic / Latino
  - ( ) Not Spanish / Hispanic / Latino
- [ ] C. NATIONAL ORIGIN
  - *(Specify)*
- [ ] D. SEX
  - ( ) Male ( ) Female
- [X] E. AGE
  - *(Date of birth)* 12/28/1960
- [X] F. DISABILITY
  - (•) Physical ( ) Mental

9. ISSUE(S) *(If your complaint concerns discrimination in the delivery of services, or employment, briefly describe what happened below.)*

False allegations from the VA, Abuse of Authority and False Inprisonment in the VA Austell Clinic Mental Health Deparment against my will. VA Austell Clinic Mental Health abducted me and transferred me to WellStar Cobb Hospital against my will on 12/15/2017 thru 12/17/2017. (Exhibit A thru Z)

10. LIST THE MOST CONVENIENT TIME AND PLACE FOR YOU TO BE CONTACTED REGARDING THIS COMPLAINT	11. PLEASE PROVIDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ATTORNEY OR REPRESENTATIVE *(If applicable)*.
anytime	

12. IF THE DISCRIMNATORY ACT DESCRIBED ABOVE OCCURRED MORE THAN 180 DAYS AGO, PLEASE EXPLAIN WHY YOU WAITED UNTIL NOW TO FILE A COMPLAINT.

13. LIST ANY PERSON *(Witness, fellow employee)* WHO CAN SUPPORT YOUR ALLEGATION *(List name, address, telephone number)*	14. HAVE YOU FILED THIS COMPLAINT WITH ANOTHER AGENCY? *(If yes, provide the name and address)* [X] YES [ ] NO
VA Police Report, VA Medical Reports, WellStar Cobb Hospital Records Exhibit A thru Z.	OIG

15. WHAT REMEDY ARE YOU SEEKING FOR THE ALLEGED DISCRIMINATION LISTED ABOVE?

Legal and Monetary

16. SIGNATURE *(Sign in ink)*	17. DATE *(mm/dd/yyyy)*
Deon D. Jones	04/01/2018

VA FORM NOV 2005 **10-0381**

EXHIBIT

Adult Psychosocial Assessment

Information provided by: ☑Patient ☐Guardian/Parent ☐Friend ☐Spouse/Significant Other ☐Other Family ☐Medical Record ☐Community Provider ☐Other:_____

Reason for Admission (in patient's own words): "I don't know why I'm here. I went to the VA for pancreatitis and then they sent me here."

Psychiatric History: Previous Inpatient Treatment ☑No ☐Yes If yes, Where: _____ When: _____
Have you been hospitalized in the last 30 days?: ☐Yes ☐No
If yes, Post discharge aftercare: Medication Compliance? ☐Yes ☐No
☐Do you have Outpatient providers: ☐No Current Provider ☐Ongoing, Current Provider:
Psychiatrist: _____ Therapist: _____ Other: _____

Medical History: ☐Denies medical conditions ☐ Does patient have any physical limitations that may alter his/her care or limit his/her learning ability or ability to provide self-care? ☐No, ☐Yes, Explain: RSD, pancreatitis, pre diabetic
Medical Conditions Reported: _____

Current Housing and Transportation:
☑Own Home/Apartment ☐Shelter/Homeless
☐Other's Home/Apartment ☐Group Home
☐ Nursing Home/ALF_____
☐Other:_____

Living Conditions:
☑Housing adequate ☐Housing overcrowded
☐Dependent on others
☐Housing dangerous/deteriorating
☐Living companions dysfunctional

Others living in the home (including children):
☑Live Alone ☐Significant Other ☐Parents
☐Spouse ☐Siblings ☐Friends
☐Others:
_____
# of Children:_____ Ages of Children:_____
Those living in the home: _____
Home Address: 1219 columns Dr Lithia Springs, GA

Current mental health and/or substance use issues at home:
Does anyone in the home have mental health issues?
☐No ☑Unsure ☐Yes
Does anyone in the home have substance use issues?
☐No ☑Unsure ☐Yes
Comments:
_____
Quality of relationships in the home: "great"
_____
Any noted changes to living arrangements post-discharge: N/A
Barriers to transportation post-discharge: NA

Method of Transport to be used at Discharge: ☐Family/Friend
☐Personal Vehicle ☑Non-emergent Transport ☐Medicaid T'port
☐Law Enforcement ☐Other: _____

Family/Support Situation (current):
☐Spouse ☐Significant Other ☐Others:
☐Parents ☐Siblings ☐Religious
☑Children ☐Friends ☐AA/NA
Ex wife supportive
_____
ROI Obtained ☐No ☑Yes ☐Refused

Who will be involved in treatment and services:
Name: Zakiya Jones
Relationship: Daughter
Name: _____
Relationship: _____
☐Patient refuses family involvement
Why: _____

Present Family and Social Support:
☑Close to family of origin ☐Somewhat close family of origin ☐Distant from family of origin
☑Supportive network of friends ☐Somewhat supportive network of friends ☐Unsupportive network of friends
☐Few Friends ☐Substance-use based friends ☐No friends
Family History & Past Family Dynamics: _____
Current Relationships with Family: healthy
Family Psychiatric History: None
Assessment of Family Attitudes: NA

Current Relationship Status:
☐Single, never married ☐Widowed
☐Significant Other ☑Divorced
☐Engaged ☐Divorce in process
☐Married
☐Separated Number of marriages _____

Patient identifies history of relationships as:
☑Stable ☐Independent of Relationships
☐Co-dependent ☐Unstable/Tumultuous
Quality of current relationship:
_____

LEVEL OF CARE DETERMINATION

The level of care decision was made by the clinician examining the patient and all recommendations are made based upon the information provided by the patient and significant others. Check the following that support the level of care assigned regardless of program option available at this facility.

ACUTE MEDICAL HOSPITAL REFERRAL

o Life threatening or potentially life threatening medical condition which prohibits the initiation of treatment.
o Medical evaluation indicated based on symptoms identified at time of assessment.

INPATIENT ACUTE CARE

o Behavior which is life threatening, destructive or disabling to self or others.
o Symptoms/behaviors indicative of need of 24 hours monitoring and assessment of the patient's condition (Circle all that apply):
Vegetative Sx Significant Weight Loss Inability to Sleep Inability to Care for Self Self-mutilation
Psychotic Depression Hallucinations Psychomotor Retardation/Agitation Acute Onset Confusion/Memory Loss
o Active psychiatric disorder with potential to interfere with treatment of serious medical condition.
o Failure at outpatient or partial hospitalization treatment evidenced by clinical instability or a MD consult indicates a condition, which precludes safe treatment at a lesser level of care.
o Condition requires a medically monitored detoxification process.
o Severe deterioration of level of functioning.

PARTIAL HOSPITALIZATION

o Symptoms/behaviors manifestations of such severity that there is interference with social, family, vocational functioning.
o Symptoms/behaviors indicative of need for increased intensity and frequency of services.
o For those patients no longer requiring 24 hour acute care but are not capable of assuming responsibility for their lives. Without partial hospitalization, there would be an exacerbation of symptoms.
o Failure of treatment at lesser level of care (i.e.: unmanageable in outpatient treatment requiring protected observation and coordination of therapeutic resources of an active partial program.)
o Demonstration of alcohol/drug use resulting in impairment of functioning.
o Moderate deterioration of usual level of functioning.

INTENSIVE OUTPATIENT

o Minimal risk of behavior which is life threatening/destructive to self or others.
o Depressed mood not related to a chronic condition.
o Chronic psychotic disorder requiring psychotherapy and management at a higher level of outpatient treatment.
o For those patients in need of a structured, group directed treatment without there would be an exacerbation of symptoms.
o Impaired to the degree that there are manifestations of disability and mild deterioration of usual level of functioning.
o Failure in outpatient aftercare or one to one treatments level with a psychiatrist or therapist and in need of intensity of services.
o Significant increase in drug/alcohol use.

OUTPATIENT

o Symptoms/behaviors indicative of need for services:
o Depressed Mood o Panic Attacks o Obsessions/Compulsions o Stress/Anxiety Causing Distress
o Impaired to the degree that there are mild manifestations of disability in interpersonal and/or occupational functioning.
o Minimal deterioration of usual level of functioning.

INITIAL PROBLEMS IDENTIFIED/JUSTIFICATION FOR LEVEL OF CARE CHOSEN

Level of Care Suggested: 1:0 (3) Emergency Medicine

Rationale for Level of Care with Response to Current/Prior Treatment: Acute Psychosis, Paranoia, Delusional

Axis I (MH/SA/MR): Schizophrenia; Acute Psychosis — **Current GAF:**

Axis II (Medical): None acutely

Axis III (Psychosocial): Meds non-compliant

Patient's Initial Treatment Track:

Adolescent Supportive Care Chemical Dependency Progressive **Stabilization** PHP IOP

ASSESSMENT COMPLETED BY

Assessment Coordinator's Signature, Credentials, and Printed Name: Rivera, AC (Chart Review) — Date/Time: 12/22/17

Name of Physician Assessment Reviewed With: Mehdi — Date/Time: 12/22/17

PATIENT LABEL

Revised 7/2016

SUMMITRIDGE HOSPITAL

Pa JONES, DEON
MR# 000025192 12/28/196
A# 10318940011 12/22/201
R. NORNIELLA MD M IPL

Activity Therapy Assessment

Diagnosis: Paranoid Schizophrenia **Age:** 56 **Unit:** Adult

Strengths: family support, communication skills **Weaknesses:** Reality Orientation, Coping Skills

Physical Restrictions/ Precautions/ Risks: 1013, Elopement Risk, Fall Risk, History of Seizures, History of Abuse, Suicidal/Self Injurious Behavior, Medically Compromised, Sexual Acting Out, Sexual Perpetrator, Sexual Victim, Withdrawal Symptoms, Thyroid Problems, Blind, Deaf, Mute, Chronic Pain, Asthma, COPD, Diabetes, High Cholesterol, Other pancreatitis, HTN, back injury in 1983, refuse to eat - fear of poisoning, THC use

Psychosocial Stressors: Lack of Support System, Family Conflict, Marital Conflict, Occupational Conflict, Educational Conflict, Severe Relationship Conflict, Homelessness, Financial, Grief and Loss, Sexual Abuse, Physical Abuse, Emotional Abuse, Molestation, Post Traumatic Stress, Post Partum Depression, Depression, Lack of Community Resources, Environmental Stress, Decreased Outlets, Other Veteran - Post Vietnam

Decision Making/Problem Solving: Independent, Needs Support, Indecisive, Impulsive, Apathetic, Poor Judgment, Totally Dependent, Other_____

Socialization Skills: Initiates Interactions, Responsive to Interactions, Occasional Interaction, Needs Prompting, Intrusive Isolating, Withdrawn, Monopolizing, Oppositional, Other_____

Communication Skills: Passive, Difficulty Identifying Feelings, Passive-Aggressive, Hyper-verbal, Aggressive, Withdrawn, Unresponsive, Mute, Assertive, Verbalizes Thoughts, Other_____

Coping Skills: Constructive Outlets, Limited Outlets, Unable to Identify Outlets, Destructive, Self-Injurious/Mutilating Behaviors, Homicidal, Suicidal, Other_____

Attention Span/Concentration: Able To Focus, Unable To Focus, Impaired Attention Span, Frequent Redirection, Easily Distracted, Preoccupied, Follows Directives, Racing Thoughts, Other_____

Frustration Tolerance: Verbalizes and Adapts, Difficulty Adapting, Devaluing Self, Devaluing Others, Abandons Tasks, Impatient, Destructive to Property, Other_____

Mood: Elated, Depressed, Angry, Anxious, Irritable, Labile, Worried, Frustrated, Euthymic, Crying Spells, Other_____

Memory/Orientation: Oriented x 4, Incongruent To Situation, Confused, Requires Reality Orientation, Severely Confused, Paranoid, Delusional, Visual/Auditory Hallucinations, Other bizarre hx, sees people outside of place pt stated. The police have falsified documents."

Self-Esteem: Hopeless, Helpless, Worthless, Self-Depreciating, Rejecting, Grandiosity, Acknowledges Strengths and Weaknesses, Self-Destructive, Difficulty Identifying Strengths and Weaknesses, Other_____